The Nairobi ACCORD

towards

Effective Community Based Action for Health

THE NAIROBI ACCORD

towards

EFFECTIVE COMMUNITY BASED ACTION

for

HEALTH

March 1997

CBHC CONFERENCE SECRETARIAT
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A smile for you

A smile costs nothing but produces a lot.
It gives profit to everyone who receives it
Without impoverishing the one who gives it.
It's duration is only one instant,
But its souvenir is sometimes eternal.

None is so rich that he never needs it,
none is so poor that he can't merit it.
It creates happiness in the family, supports business.
It's the most sensible sign of friendliness.

A smile gives peace to everyone who is tired,
It encourages the most discouraged.
It can't either be bought, nor be lent , nor be stolen,
Because it's a precious thing
Only when it's given.

And when you meet someone who can never smile;
Please be generous to give him your smile;
Because none doesn't need it as well as
Who can give to the others.

By Kivunda K.

An Ode to CBHC

So often have I been told
Of the need to sacrifice
In order to reach out
To people in communities.

I do sense that there is need
To share experiences with communities;
To nurture compassion with communities
By going to work with them.

But no one told me
How much I would gain
By working with people
In their communities!

Thank you CBHC
For taking me back to the people!
Thank you CBHC
For Providing a context
For healing.

By Miriam Were

Hon. J. K. General Mulinge
Hon. Minister for Health - Kenya

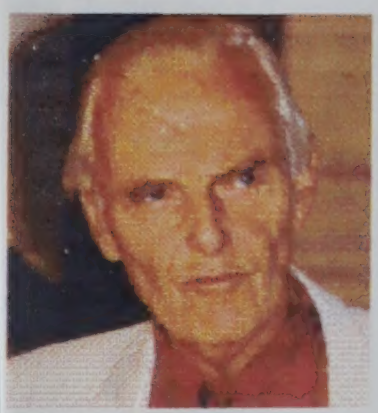
Dr.Miriam Were
Director UNFPA-CSTA (A PHC pioneer in Africa)

Prof. Ransome-Kuti
Chair, Better Health for Africa, Expert Panel, World Bank

Prof. Mukelabai K.
UNICEF Country Representative

Rose Aoko Otieno
A CORPs Representative

Dr. John Martin
WHO, Geneva



Dr. Chris Wood
A pioneer in CBHC

Ms Penina Ochola
CBHC Consultant

Dr. Michael Gerber
AMREF Director General

EXECUTIVE SUMMARY

We the participants at the First International Conference on Community Based Health Care (CBHC) in Nairobi this, 21st day of March in the year Nineteen Hundred and Ninety-Seven unite in ***calling for*** urgent individual, community, agency, national, and international action to develop and implement CBHC throughout the world. It urges governments, WHO, UNICEF, UNFPA, other international organisations, multilateral and bilateral agencies, religious organisations, non-governmental organisations (NGOs), funding agencies, health and development workers and the world community at large, to support an international, national and community commitment to CBHC development. It urges the channelling of increased technical and financial resources towards this effort, particularly in developing countries. The participants of the Conference ***resolve to collaborate*** in introducing, developing, managing, and maintaining CBHC in the spirit and content of this Accord.

The Conference participants ***resolve to struggle*** on the side of the most vulnerable and the poor in rural and urban communities; they ***advocate*** for good governance, ensuring accountability to communities in which we live and serve, democratic principles, increasing transparency as well as basic human rights and increased role and status of women. The participants plead for space to allow community involvement in the formulation of policies and in decisions that affect the allocation of resources, in keeping with the priorities of the poor. The participants resolve:

- To serve as **prime movers** for change in partnership with all concerned agencies and citizens of our world, in relieving the plight of the poor and suffering, making health a possibility for them.
- To **facilitate and promote** new partnerships that will create and maintain an enabling environment for community self reliance, empowerment and transformation.
- To **lobby** the policy makers to ensure the renewed commitment to the goal of Health for All through the CBHC approach.

The Conference challenges us all to subject our past and present realities to a radical appraisal; to **undertake a critical analysis** of the causes, consequences and cures of ill-health, poverty, dis-empowerment and underdevelopment. There is need to examine the institutions, concepts, policies and practices that shape the inequitable global economic system that impinges on the health of the people. By doing this, we should find the motivation to renew our commitment to the Health for All strategy through CBHC. This is a process that must lead to the **transformation** of systems and societies in which we are involved. It leads to the **liberation** of each individual from personal, social, cultural, political and economic limitations, and empowers each person for the achievement of their full potential, towards the Health for All goal.

A SUMMARY OF KEY RESOLUTIONS

1. The Concept of Health

Recognising that health continues to be understood merely as the absence of disease, requiring vertical medical interventions, the Conference strongly ***reaffirms*** that health is not only the absence of disease but also the presence of peace, justice, integrity, and harmony with self, family, neighbour, nature and God. Health for All is only attainable through **joint action** beyond the health sector, using the **Community Based Health Care (CBHC)** approach.

2. Participation of Communities' Own Resource People (CORPs)

Noting that the unique element in this Conference was the effective participation of the Communities' Own Resource Persons (CORPs), such as Community Health Workers (CHWs), Traditional Birth Attendants (TBAs) and community leaders, the Conference ***affirms*** the capacity of CORPs to engage fruitfully at all levels of the health system. The Conference ***urges*** all intergovernmental organisations, governments, non governmental agencies, and community based organisations to include community representatives in all fora (meetings, workshops, conferences, seminars) discussing issues that affect directly, or indirectly the lives of communities and to facilitate their effective participation. The CORPs ***reaffirmed*** their commitment to spearhead action for Health for All beyond the year 2000. They **appealed for opportunities, not gifts, to enhance their capacity for self-reliance.** The CORPs voiced their concern that **they should not shoulder blame for failed programmes that have not involved them in the design, monitoring and evaluation.**

3. Supporting Community Based Programmes

Concerned that the existing government policies are either inaccessible or difficult for communities to meaningfully interpret, and that the Government induced community programmes like Bamako Initiative (BI) pharmacies are neither well equipped nor supported, the Conference ***appeals*** to governments, and all other participating agencies:

- To involve communities in policy review, formulation, implementation, monitoring and evaluation, in all matters affecting communities.
- To provide the necessary practical support through training, supervision, and implementation guidelines.
- To direct available resources towards integrated comprehensive community based programmes that enhance social mobilisation, and that includes the essential elements of health care, poverty alleviation, basic education and environmental preservation, targeting disadvantaged groups.
- To ensure that Community Based Action for Health is integrated into each country's health care system as its central function and the driving force for overall social and economic development of the community.

4. Training and Leadership Development for CBHC

Recognising that health workers are seldom adequately trained as facilitators of community action for health and that there is scarcity of knowledgeable, skilled and experienced leadership for CBHC to at all levels; and that this has led to the distortion of health strategies and practices into fragmented, "quick-fix", vertical, technical interventions, planned and managed from the top, and that there are no strong voices at community, national and international levels advocating for health as has been heard during this Conference, the Conference ***appeals*** **to WHO and UNICEF, in collaboration with donor agencies to promote and support community partnerships in the selection and training of health personnel, and that focus be placed on the development of people, rather than systems and structures,** to produce competent leadership for advocacy and creativity in Community Action for Health.

5. Promoting Access to Essential Care through CBHC

The Conference ***notes*** that in spite of the impressive advances in science, technology and medicine in recent years, the vast majority of the world's population are still beyond the reach of their country's health service. More than 80 per cent of people live in rural areas or in city slums where long distances and/or poverty deny them access to basic, essential care. Since the extent and type of health problems, particularly in poor and vulnerable communities can neither be addressed solely by medical interventions, nor by health service systems alone, the Conference ***emphasises*** that the responsibility for health improvement and maintenance should be shared among communities, health service agencies and health professionals. There is need to recognise the knowledge, skills, experiences, ideas and opinions of the communities as legitimate and vital in meeting their own needs.

The Conference is ***aware*** that the deteriorating economic situation all over the world has increased the diseases of deprivation, evidenced by the numerous epidemics and the resurgence of major communicable diseases such as malaria and tuberculosis. The diseases of development such as hypertension, diabetes and alcoholism have also increased. New challenges, particularly HIV/AIDS, have defied medical technology and are overwhelming the already fragile health care systems.

This Conference ***urges*** governments, NGOs, the private sector, health care institutions, Community Based Organisations (CBOs), and communities to facilitate and support family based care of the sick, utilising available resources without increasing the burden disproportionately on the most vulnerable: women, children and the elderly. The Conference ***calls*** for the strengthening of people's capacity to cope with both the old and new challenges of care in the context of extreme social economic hardship, through partnerships modelled according to existing community based systems. There is need for increased partnership between professional providers, communities, families and individuals in meeting the demands for care.

6. Strengthening Community Based Institutions and Structures for CBHC

Noting that community institutions developed by external agents for project implementation necessarily cease when external financial support ceases, the Conference ***recommends*** that community partnership be based on existing traditional community structures, initiatives, investments, assets, capacities, experience, expertise, resources and the most appropriate technologies and strategies. Partnership with external donors will require a community-appointed intermediary, who does not compete with the community for its own meagre resources, but protects the interests of the poor against the greed of the local elite. Local structures include extended family networks, schools, churches and other religious or association groups. The Conference ***calls upon*** families, communities, CBOs, NGOs, Governments, and intergovernmental **agencies to recognise and support such structures** as vital anchor sites for community action for health and development. There is need to establish partnerships and coalitions for health and healing around each structure, based on existing strengths, methods and expertise.

The Conference ***urges*** all concerned agencies and partners to create an environment in which healing is an integral part of the life of the congregation or group. It is essential to develop tools, methods and techniques for building such healing communities and activities through these mutual caring healing groups. Guidelines, manuals and action-oriented training on how to start and manage healing groups are needed. It is important to recognise the practices and rituals in the community and congregations that build mutual loyalty. Mechanisms for obligatory sharing and caring, compassion, cooperation, collaboration and cooperation are important factors within a comprehensive socio-cultural context. There is need to enhance the **capacity of all to be healers of one another** for achieving **Health for All** through **action by all.** The Conference ***appeals*** to intergovernmental, Government, and non governmental health agencies and networks to recognise and strengthen these structures and alternative healing systems and resources, as essential elements in the health system. There is also need to establish mechanisms for collaboration.

7. Documentation, Information and Research in CBHC

The Conference ***notes*** that even where the current methods of health information systems adopted and used at community level are appropriate with regard to level of skill, cost effectiveness and dissemination potential, the flow of information is predominantly directed to serve the national system or government purposes. Similarly, research carried out in the community is rarely shared with nor benefit them. The Conference ***appeals*** to all concerned partners:

- To recognise, and promote community based participatory approaches to assessment, monitoring, evaluation and research.
- To develop comprehensive guidelines for participatory methods in community based information systems, ensuring community leadership and ownership of processes and results of research and evaluation.

The Conference ***appeals*** to all partners to demystify research and to involve communities in determining the research agenda. Communities should be encouraged to be more observant, inquisitive and analytical in their day to day life, and to appreciate the value and use of research in trying to solve their problems.

8. Addressing Poverty through CBHC

The Conference ***notes*** that the root causes of poor health are to be found in the persisting unjust social, economic, and political structures that determine the distribution of resources, services and power in the local and international arena. Thus the achievement of Health for All will be determined less by services and external resources and more by the fairness of social, economic and political structures. Therefore the Community approach to health development is inseparable from the struggle for a fairer, just, and more caring society.

The Conference ***recognises*** that the improvement in the mortality trends in the 1950s, 60s and 70s has been slowed or even reversed in the 80's and 90's due to the global recession and the debt-driven, export-oriented structural adjustment programmes. The impact is greatest among the poorest people without safeguards to ensure access to essential services.

The Conference ***recognises*** the adverse effects of macro-economic policies, as a result of prescriptions of the World Bank and the IMF, on the poor, it is ***concerned*** that there are propositions to improve services by allowing free markets to take over, without democratic controls. Emphasis is on economic growth despite its human, and environmental costs that may discriminate against the poor. The Conference is ***aware*** that the existing inequities in health status at community, country and international levels are economically determined, are unacceptable and are common concerns to all people of the world.

The Conference is ***convinced*** that achieving Health for All is dependent on reducing inequities in health status and access to health care. It ***notes*** that the period since Alma Ata has been characterised by a dramatic widening of the equity gap and a doubling of the number of people living in extreme poverty to 1.5 billion. Of the extremely poor, 16% live in sub-Sahara Africa that has half the population of the region.

The Conference therefore ***appeals to*** CBOs, NGOs, governments, intergovernmental organisations and donor agencies to preferentially support integrated, comprehensive programmes that include sound, poverty reduction and international fair pricing schemes, as essential elements of CBHC. It appeals for assistance for the poor to engage in activities that improve their economic status. The impact of CBHC activities must be measured in terms of improved health status of the poorest households in the population. Measurement must be based on health and economic indicators to permit analysis of all factors affecting the wealth and the health of the community. In this way, communities can make informed choices on a wide range of issues affecting their health and well-being.

9. CBHC in Disaster and Emergencies

The Conference ***notes*** that changes often happen during crises and problems when people are forced to consider the need for change more seriously. Communities are usually not well prepared to cope with disasters and emergencies. The Conference ***urges*** governments and non-governmental organisations to facilitate participatory needs and capacity assessments in target communities. In addition, there is need to strengthen community based coping mechanisms, as part of their disaster prevention and preparedness activities. Strengthening institutions that are closest to the communities like CBOs, NGOs, churches and schools would add significantly to preparedness at the community level.

This Conference ***appeals*** to all stakeholders - CBOs, NGOs, governments, intergovernmental agencies and donors to work in partnership with local communities to carry out rapid assessments to determine the need and level of initial inputs into the relief. Prior to any intervention, there is need to carry out a detailed assessment to guide longer term response and to develop standard protocols relevant for different types of disasters.

The Conference is ***concerned*** about the non recognition of the capacities, efforts and contributions of the local communities in response to disasters and emergencies by external agencies and the media. Yet local communities are usually the first respondents to any disaster situation. They are also the first to run out of their compassion, food, energy, health services and other resources. When confronted with these issues, they usually do not have skills or indigenous organisations for disaster response. Relief interventions relegate people to recipients and clients, and thus undermine their coping capacity and mechanisms. As a result, they rarely use traditional resources due to emphasis on external technical and material inputs that often arrive too late and stop too early.

This Conference ***requests*** governments and collaborating NGOs to initiate, strengthen, keep in a state of preparedness and use existing systems and structures at all levels and in all sectors. There is need to involve local communities in all stages of planning and decision making, implementation and evaluation relief and rehabilitation activities. There is need to strengthen community capacities in all entry borders, to compile an inventory of existing resources and to predict the potential deficit resulting from utilisation by disaster victims.

Participants at the First International CBHC Conference - March 1997

THE NAIROBI ACCORD

towards

EFFECTIVE COMMUNITY BASED ACTION FOR HEALTH

Preamble:

In 1977 the World Health Organisation, through the World Health Assembly and its members states set the global objective as the achievement of Health for Allby the year 2000, that is, the attainment by all citizens of a level of health that permit them to lead a socially and economically productive life. The Alma Ata Conference of September 1978 reaffirmed the global objective and resolved that Primary Health Care was the strategy for achieving Health for All. The strategy is based on the principles of equity, linkage to the overall social-economic development, accessibility, clear presentation in national policies, a community based health care approach focusing on the community's own agenda, and intersectoral collaboration.

While significant progress was made in the 1980s in formulating policies, serious gaps in the implementation of the Primary Health Care strategy are yet to be addressed beyond the policy level to the intermediate and community levels.

The First International Conference on Community Based Health Care (CBHC) held in Nairobi, Kenya from 17-21 March, 1997 brought together community people, NGOs implementing community based health programmes, researchers from universities, the private sector, donors and governments. The Conference availed an opportunity for key players to exchange experience in community based health and development initiatives since the Alma Ata Declaration. It gave opportunity for stock-taking, reflection and assessment of achievements to date in community based actions in health.

The Conference covered six specific sub-themes, namely:

1. **Enabling Environment for Health**
2. **Community Action for Health**
3. **Health, Healing and Wholeness**
4. **Information, Dissemination and Communication**
5. **Poverty and Health**
6. **Action for Health in Disaster, Emergency and Conflict.**

These sub-themes reflect the current rapidly changing and dynamic environment. Some of these issues were not considered, nor given due emphasis during the Alma Ata deliberations. The outcome of the deliberations on these specific areas during the CBHC Conference has led to the development of the Nairobi Accord towards effective Community Based Action for Health. The Accord contains recommendations for the renewal of commitment to the Health for All strategy, based on field experiences.

The most visible uniqueness of this Conference was the high-profile presence and participation of Communities' Own Resource Persons (CORPs) who gave leadership to the Conference in identifying and deliberating on the following specific issues, requiring urgent action:

1. **Leadership development and training for community based action for health**
2. **Reciprocal and inclusive involvement in action for health at all levels**
3. **Strengthening local community structures and methods for health and healing**
4. **Developing community based research and information systems for CBHC**
5. **Addressing poverty through CBHC**
6. **Implementing CBHC in disasters and emergencies**

The Conference sets the stage for a collective and participatory review of progress in the implementation of the Health for All strategy. It also suggests concrete action now and beyond the year 2000. The resolutions passed shall herein after be known as **THE NAIROBI ACCORD.**

THE NAIROBI ACCORD

We the participants at the First International Conference on Community Based Health Care in Nairobi, this 21st day of March in the year Nineteen Hundred and Ninety-Seven unite in expressing the need for urgent action, by all participants, intergovernmental agencies, governments, non-governmental agencies, religious organisations, and all health and development workers in partnership with the world community to protect and promote the health of all the people of the world. We hereby, make the following declarations:

1. THE CONCEPT OF HEALTH

The Conference ***recognises*** that the practice of modern medical care is dominated by western concepts and practice of health care, and that non-western concepts, skills and techniques tend to be ignored; the conflict between these healing concepts has hampered the implementation of Primary Health Care (PHC) as expressed in the Alma Ata Declaration and that health continues to be understood merely as the absence of disease, requiring vertical medical interventions.

The Conference thus strongly:

- ***Reaffirms*** that health is not only the absence of disease but the presence of peace, justice, integrity, harmony and spirituality. It is a state of well-being in person, family, neighbour, nature and possessions, including harmony in human relationships that permits mutual sharing and caring to take place, enabling all people to live with a minimum of dignity.

- ***Reaffirms*** that the attainment of this kind and level of health is the most important worldwide goal whose realisation requires joint action beyond the health sector, to social and economic sectors and into communities, through **Community Based Action for Health.**

2. THE COMMUNITY BASED AGENTS OF CHANGE (CHWs, TBAs, Community Leaders)

Noting that the most unique element in this Conference was the presence of the Communities' Own Resource Persons (CORPs), as consultants to the Conference, reflecting on the discussions of each day and giving feedback to presentations by policy makers, academicians and other Conference participants, this Conference ***affirms*** the Capacity of these Community Based Agents to engage fruitfully in discussions at all levels and ***urges*** all intergovernmental organisations, governments, non-governmental agencies, and community based organisations to:

- Include community representatives in all future fora (meetings, workshops, conferences, seminars) discussing issues that directly or indirectly affect the life of communities, and to facilitate their effective participation.
- Develop mechanisms for the selection and participation of community based agents at all levels of debates and discussions.

CBHC, CORPs participants at the Conference

- Develop training programmes that would enhance the existing capacity of community agents at district, national and international levels.

The Conference further endorses the following resolutions and recommendations that were spear-headed by these Community Resource People:

2.1 Participation in policy review, formulation and implementation

Concerned that the existing government policies are mostly unilaterally formulated, inadequately disseminated and seldom targeted at identified communities' needs, and that Government induced community programmes such as Bamako Initiative (BI) pharmacies are neither well equipped nor supported, and that failures to such programmes, for example, the training of TBAs to reduce maternal mortality, are blamed on these Community Based Care providers, the **CORPs** ***appeal*** to governments, non-government agencies, the private sector and community based structures to:

- Involve community agents in policy review, formulation, implementation, monitoring and evaluation, in all matters affecting them.
- Enhance awareness among the policy makers, donors and communities of the centrality of community involvement to the achievement of Health for All, and that such involvement should be based on communities' own capacities, resources, initiatives and ideas.
- Establish functional and reliable systems of procurement and supply of drugs and nets to the BI pharmacies, to maintain the highest possible quality of care and thus discour-

age the use of untrained sources, quacks and shopkeepers. This may be done through appropriate community appointed intermediaries.

- Provide continuing training for managers of BI pharmacies to enable them to analyse data collected, and to take corrective measures without necessarily having to refer to the Ministry of Health.
- To review the guidelines and strategies for the establishment and management of BI programmes, with the aim of making them more community friendly.

2.2 Leadership identification and development

There is lack of a critical mass of concerned and committed leaders for Community Based Action for Health in many communities to lead CORPS in tackling their own problems. The existing community structures need strengthening to cope with the dynamic context in which they operate. The **CORPs** therefore ***demand:***

- The involvement of the community in the selection of community members to be trained in health and development by NGOs and government ministries, focusing on commitment and not only academic qualifications.
- The involvement of the communities in curriculum design, and in the training and supervision of trainees.
- The formulation of coherent programmes for the identification and development of leaders for community action for health, including the design of new relevant and practical oriented courses which are sensitive to community needs.
- Training programmes which are well built into the normal day-to-day schedule of trainees activities, with regular feedback, allowing periodic review and updating of courses offered.
- The identification, support and strengthening of relevant community based organisations (CBOs) to enhance the capacity of communities for equal partnership with other agencies.

2.3 Appropriate Savings and credit facilities for the poor

Concerned that the existing credit facilities are neither appropriate to the needs, nor accessible to the rural poor, the **CORPs** ***appeal*** to the private sector, the banking industry, NGOs and governments to:

- Implement credit schemes which are community friendly
- Mobilise and sensitise community leaders and members on how to acquire and manage credit, and to develop and strengthen a mutual guarantee system.
- Improve the food security situation, through careful promotion of cash-crop farming and marketing, facilitating the improvement of food storage practices and the promotion of agro-processing initiatives within communities.

2.4 Disaster prevention, preparedness and management

2.4 Disaster prevention, preparedness and management

Recognising that Communities are usually not well prepared to cope with disasters, emergencies and armed conflicts when they arise, **CORPs *urge*** governments and NGOs to facilitate participatory needs and capacity assessments. This will strengthen the community based coping mechanisms, as part of their disaster prevention and preparedness activities. Strengthening institutions and structures that are closest to the communities such as CBOs, NGOs, churches and schools would add significantly to preparedness at the community level. Additional aspects are investing in peace initiatives, reconciliation, conflict resolution and establishing just and democratic systems of governance.

2.5 Community Based Information Systems

Noting that the information pertaining to health and development is rarely accessible to communities, and is often not user-friendly, and that research carried out in the communities are usually too empirical and technical to be of use to them, the **CORPs *insist*** that:

- Governments, NGOs and communities collaborate in establishing and equipping community resource centres for essential health and development information.
- Community, leaders, representatives and structures should be involved in all stages of research in the community, to enable the community to influence the definition of the research agenda.
- There should be a shift of emphasis from empirical to action-oriented research.
- Research agendas should be generated from community priority needs, challenges and innovations.
- Research documents should be promptly produced and shared with all stakeholders, especially the communities.

The CORPs ***reaffirmed*** their commitment to community involvement and participation as a major strategy in the attainment of Health for All beyond the year 2000. They however note that they will need opportunities, not gifts, to enhance their capacity for self-reliance. They need further training in their areas of interest, within the existing government or non-government system. They noted that they should not shoulder blame for failed programmes that have not involved them in the design, monitoring and evaluation.

3. ENABLING ENVIRONMENT FOR COMMUNITY BASED ACTION FOR HEALTH

The Conference ***noted*** that the root causes of poor health are to be found in the persisting unjust social economic, and political structures that determine the distribution of resources, services and power in the local and international arena. The achievement of Health for All will be determined less by services and external resources, and more by the fairness of social, economic and political structures.

The Conference ***recognises*** that the pursuit of the community approach to health development is inseparable from the struggle for social justice and a fair, just and more caring society

This Conference therefore ***strongly suggests*** that the renewal of commitment to the Health for All strategy must address the current political, health development, demographic, epidemiological, cultural, economic and environmental context targeting the most destitute of our communities.

3.1 Participatory policy review, formulation, analysis and implementation

The Conference ***realises*** that while governments have the responsibility to provide basic health care to all their citizens, government action alone is inadequate for attaining the global goal of Health for All. There is ***concern*** about the negative effects of global and national policies, and economic trends on Community Based Action for Health. These factors adversely affect the poorest population groups.

This Conference ***recommends*** to governments, intergovernmental, non-governmental and community based organisations, and communities that:

- Available resources to be directed towards integrated, comprehensive community based programmes that enhance social mobilisation, which include the essential elements of health care, poverty alleviation, basic education and environmental preservation including food security, targeting the most disadvantaged groups: the poorest of the poor. In doing so, action should be taken at the level of the donor community, governments, NGOs and the private sector.
- All governments to formulate national policies, strategies and plans of action to launch and sustain Community Action for Health as part of the comprehensive national health system, in co-ordination with all key players. There is need to generate political will for mobilising resources at all levels, to re-allocate them appropriately, and to use external resources rationally.
- Concerned agencies to carry out a systematic participatory review of existing policies, to enable a shift in resource allocation and formulation of strategies to facilitate Community Based Action for Health and development.
- Donors to direct available resources towards integrated, comprehensive, community based programmes, focusing on social mobilisation, water and sanitation, education for health, and sound poverty alleviation initiatives.
- Strategies be established to generate relevant health policies from the community level, and to systematically consolidate them to the district and national levels.

The Conference ***affirms*** that the Community Based approach is the key to progress to the Health for All goal, as an integrated, holistic and comprehensive development in the spirit of social justice.

3.2 Deterioration of quality of Health Care in spite of increasing costs

Aware that access to and quality of health care is constantly deteriorating, even in countries where the per capita expenditure exceeds the WHO prescribed minimum level, the Conference ***strongly affirms*** that:

- The renewal of commitment to the Health for All strategy must re-focus on improving efficiency and effectiveness of health care delivery. There should be more emphasis on Community Based Action for Health, integrated into the country's health care system, of which it is the foundation, central function and the driving force for overall social and economic development of the community
- The CORPs need recognition and non-monetary incentives based on their inputs in leading health action at the Community level.

The Conference ***recognises*** the capacities and resources in each individual, family and community to cope with their most basic health care needs, thus establishing the first element of a continuing health care process that rests on people's own skills, resources and capacities.

3.3 Support to Bamako Initiatives (BI)

Noting that many countries have successfully initiated the Bamako Initiative as a way to enhance access to essential drugs at affordable prices, and to stimulate community financing of essential health care at the community level, yet there may be no policy framework for their management and support.

Aware of the fact that communities have not been supported and enabled to ensure rational and safe handling of drugs and to ensure sustainability, community resource persons have expressed a need for consistent and transparent support in the areas of training, procurement, distribution, and the management of revolving funds.
The Conference, led by the group working on the sub-theme Enabling Environment, ***urges*** governments, NGOs, CBOs, and the private sector:

- To develop or review the National Drug Policy to include procurement, storage, distribution and rationale use of drugs by health workers. It should also include the law and law enforcement regarding drug handling and management, generic standard drug lists and the drugs to be used at various levels of the system, thereby strengthening the referral system. There should be regulation on the number of drugs and a restriction on drug promotion to protect communities.
- To provide support to communities implementing BI activities in training, procurement and distribution of supplies, supervision, financing and financial management, monitoring, evaluation and operations research.
- To formulate policies that are more problem and people-centred, to reduce under or over medication and excessive promotion of drugs; develop and implement relevant public education on rational use of drugs and improve on communication skills; establish quality control laboratories in countries and regions; develop standard training programmes and training materials for health workers at all levels; and streamline and co-ordinate procurement of drugs by communities to avoid ad hoc donations from donors which leads to overstocking and expired drugs.

4. TRAINING AND LEADERSHIP DEVELOPMENT FOR HEALTH

The Conference ***recognises*** the fact that health programmes are staffed by health workers who are seldom trained for community partnerships tasks; there is scarcity of knowledgeable, skilled and experienced leadership for community based approach to health at all levels which has left room for a distortion of health strategies and practices into fragmented, "quick-fix", often vertical, technical interventions, planned and managed from the top. These strategies avoid serious engagement in a community-based process towards genuine changes in favour of the poor. There are no strong voices at community, national and international levels advocating for effective action for health at the level of each community as has been heard during this Conference.

The Conference ***notes*** the importance of focusing on the development of people rather than systems and structures as a priority, because people can then develop the structures. Focusing on people also enhances accountability. Structures, when developed, do not seem able to develop people on whom they depend.

Efforts should be made **to facilitate partnership** between the organised institutions, resource bases and the community which allows some power sharing and even a measure of community control and accountability.

The Conference ***calls upon*** governments, academic institutions, NGOs with the support of intergovernmental organisations and donor agencies to:

- Support and develop appropriate training programmes for health workers on CBHC, taking into consideration the available resources, community needs and the professional needs of the trainees. Such programmes should be community based, with problem-solving and action-oriented curricula. Curricula for specific community projects should be developed after participatory training needs analysis has been carried out in the communities.
- Identify, develop, engage and support current and potential leaders at all levels (community, district, national and international) to produce competent leadership for advocacy and creativity in Community Action for Health. This can be done through appropriate training activities, cultivating the skills and attitudes of individuals who are strategically placed to mobilise others.
- Equip all persons with the necessary knowledge, skills and attitudes necessary to play their role effectively in health action.
- Develop a network of interested government sectors, NGOs and districts to provide opportunities for sharing innovations, mutual support and encouragement as well as mechanisms for fostering political commitment and will. This leads to a "critical mass" of prime movers, anchor persons and anchor sites in every community, district, or country in order to generate the collective force necessary for the promotion of sustainable health and social development of communities.
- Develop mechanisms for greater accountability to communities served, with all partners balancing their rights against their responsibilities.

5. PARTNERSHIP AND PARTICIPATION

The Conference ***reaffirms*** that people have the right and duty to participate individually or collectively in all the decisions, programmes and policies that affect their lives, particularly in health care and development. The Conference ***underlines*** that people's involvement in health and development is not new. In coping with the problem of how to stay alive and well, millions of poor people have little to support them, but their own knowledge, resources, skills and efforts. What is new is the notion that professionals can be in partnership with communities in their health care activities. Such partnership leads to mutual empowerment of all the partners, each being enhanced in his/her contribution according to individual strengths and experience.

The Conference ***recognises*** that the community capacities and resources for health are based on the long experience of communities and their own action research. Their involvement beyond their extended family domain evolves from the economic conditions and socio-cultural and political characteristics of the countries, districts and communities.
The Conference ***notes*** that the impressive advances in science, technology and medicine in recent years still leave the vast majority of the world's population beyond the reach of their country's health or social welfare services. More than 80 per cent of people live in rural areas or in city slums where long distances and/or poverty deny them access to the often over-sophisticated but not necessarily high quality urban-centred services.

Observing that the extent and type of health problems, particularly in poor and vulnerable communities, can neither be addressed solely by medical interventions, nor by health service systems alone, the Conference ***emphasises*** that the responsibility for health improvement and maintenance must be shared among communities, health service agencies and health professionals. A process should be used in which all, especially the most poor, work together to increase their control over the events influencing their health and well-being. The process should use a community based approach, leading to all partners becoming less dependent on outside resources, services and regulations. This calls for the recognition of the knowledge, skills, experiences, ideas and opinions of communities as legitimate and vital in meeting their own needs.

The Conference:

- ***Affirms*** that the community based approach is key to CBHC as it is the approach that builds on existing strengths, assets, and capacities. It enhances people's ability to cope with daily needs in health and development, supported by the holistic health team from the family, community, district and national levels.
- ***Urges*** all partners to facilitate a process in which communities can invests themselves and their time, take risks, agree on what external assistance is most appropriate and under what terms, to ensure that such inputs augment, rather than replace the local ones.
- ***Lays emphasis*** on self-reliance with appropriate support from the referral system, leading to progressive improvement towards health care for all, while targeting the poorest of the poor in urban and rural areas.

5.1 Participation

The Conference ***notes*** that community participation, as defined by service providers, continues to be donor induced or driven, where traditional functions and obligations become professionalised to be sold for money. Such externally determined functions and participation usually do not continue beyond the period of donor funding.
Consequent to this, accountability in most projects, is to sponsors and funding agencies and not to the target communities. As a result an unequal partnership in which communities are expected to contribute labour or material resources but are not expected to make decisions or contribute ideas. They thus remain passive recipients of the interventions designed by the project leaders, with minimal community input or control.

Recognising that community strengths, capacities and abilities are basic building blocks which should be connected and pooled in ways that multiply their power, the Conference participants led by the group at the workshop on community participation, ***urges*** all agencies and service providers to facilitate meaningful community participation by:

- Facilitating community involvement in the design, management and control of interventions by establishing systems for inclusive representation of the target community members at the various levels of decision making; and ensuring that communities views are heard, and included.
- Strengthening local initiatives that reinforce community participation; identifying Communities' Own Resource People, understanding their roles and establish their capacities and abilities for community action.
- Establishing mechanisms of accountability to communities by NGOs and service providers, advocating for decentralised policy implementation, service delivery, and emphasising policies that promote participation.
- Including communities in planning, assigning of responsibilities as well as recruitment of project personnel.
- Ensuring gender balance at every level of activity, to ensure gender needs are voiced considered and incorporated in project implementation.
- Educating and sensitising donors to inculcate greater responsiveness to community needs.
- Using the most appropriate technology in activities.
- Identifying and working with anchors, prime movers, and champions of local initiatives and harnessing local institutions; reassembling community assets and strengths into new combinations, structures, resources of income and control, and new possibilities for production.
- Focusing internally and on people by concentrating on the agenda-building and problem-solving capacities of local residents, associations and institutions; emphasising the local primacy of definition, investment, creativity, hope and control and being more aware of social and environmental factors influencing the situation of people.
- Being relationship-driven as the main challenge in our world today is to build and rebuild relationships between and among people, institutions and structures. It is the strong ties that form the basis for community participation in health and development. The forces that are driving people apart are many: mobility, media, technology, ethnicity segregation and professionalisation of all activities. These exteriorise normal functions,

making them inaccessible by not recognising, ignoring or marginalising the traditionally existing ones.

- Providing opportunity for individual and/or collective reflection to ensure a process of continuous community reflection and action. This will encourage flexibility to allow continuous improvement and adjustment as communication improves, resulting in greater mutual knowledge of partners and situations.

5.2 Community Based and Family Focused Care

The Conference is ***aware*** that the deteriorating economic situation all over the world has increased diseases of deprivation, evidenced by the numerous epidemics and the resurgence of major communicable diseases such as malaria and tuberculosis.

Of ***concern*** is that the diseases of development such as hypertension, diabetes and alcoholism have also increased. New challenges, particularly HIV/AIDS, have defied medical technology and are overwhelming the already fragile health care systems.

This Conference ***urges*** governments, NGOs, the private sector, the health care institutions, CBOs, and communities to facilitate and support family based care of the sick, utilising available resources without increasing the burden disproportionately on the most vulnerable: women, children and the elderly.

The Conference ***calls*** for the strengthening of people's capacity to cope with both old and new challenges of home-based medical care, in the context of extreme social economic hardship. It encourages partnerships modelled according to existing community based systems of care, with increased partnership between professional providers, communities, families and individuals in meeting the demands for care.

The Conference ***appeals*** to governments:

- To recognise and appreciate the training of TBAs on modern health practice.
- To support further training of CHWs to make them more effective.
- To extend the support from the community level to other sources of motivation for CHWs, other than cash payment.

6. COMMUNITY STRUCTURES FOR HEALTH AND DEVELOPMENT

6.1 Sustainability

Noting that community institutions developed for project implementation necessarily cease when external financial support ceases, the Conference participants, led by the group at the workshop on sustainability strongly ***reaffirms*** that:

- Actions for Health and development must be community-driven to ensure relevance to community felt needs and the desire to sustain the programmes.
- Actions are based on existing community structures, strengthened and oriented for

their role in programme development and management.
- The end of partnership with a community is planned from the beginning, including the gradual disengagement process.
- The most sustainable programmes are those based mostly on communities' own initiatives, investments, assets, capacities, experiences, expertise and resources, as well as the most appropriate technologies and strategies.
- Development of support systems and capacity building by identifying independent community leaders.
- Promotion of sound resource development and management strategies built on traditional systems and community capacities.
- Professionalisation of traditional functions is avoided.
- Policy and planning at the macro or national level should reflect a reorientation from the medical model of health system and service delivery to the *Health Oriented Model*. There is need to clearly emphasise a development approach for improved access to the broader components of basic human needs and health services, medical care being only one aspect.

6.2 Participatory School Health

Recognising that childhood is the best time to inculcate a healthy lifestyle, the Conference urges the involvement of schools that provide the greatest opportunity to improve health by encouraging development of behaviour that sustain health, skills to deal with illness early and skills to assist those who may become sick or get injured.

The Conference is ***concerned*** that so far, knowledge and skills acquired at school is not shared in the community. School health activities are not given priority as other areas of development by funding agencies and communities. Additionally, teachers are not adequately trained or prepared to facilitate school health programs. Communities are often not even aware of the importance of improving environmental health around schools, such as providing safe water and sanitation. The school is not recognised as a valuable community based structure and focal point for health and development initiatives.

The Conference participants led by the working group at the workshop on community action for health ***calls upon*** families, communities, CBOs, NGOs, governments, and intergovernmental agencies to:

- Recognise schools as vital anchor sites of community action for health and development which should be integrated into the national system.
- Develop teacher training curricula that include knowledge, attitude and skills for planning and implementing comprehensive school-based health and development projects.
- Initiate partnerships for health and development around each school community, for popular involvement in school health activities such as sinking of wells, building latrines, protection of environments, school gardens or farms; and to undertake joint health activities that bring school children, teachers and parents together engage in tangible actions for shared learning and lasting impressions.

7. PARTICIPATORY DOCUMENTATION, INFORMATION, ACTION RESEARCH AND COMMUNICATION

The success of CBHC programme management depends on relevant information collection, analysis and presentation. The aim of an information system is to increase efficiency, flexibility, appropriateness and accountability in programme management for all stake-holders: the community, the project team, the government and donors. Health information is required to provide all stake-holders with essential information that enables timely and efficient decision-making, ensuring equity in health and participation of the community in health management and information.

7.1 Appropriate information systems and research in Community Health and Development

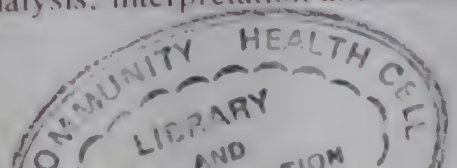
The Conference is ***concerned*** that health information systems have not considered and incorporated communities' indigenous ways of handling information and communication, and that the current methods used to collect, document and communicate the activities and outcomes of CBHC programmes do not provide relevant information that will serve the purpose of CBHC and the interests of the target communities and their support systems.

The Conference **recognises** that a community based information system is an integral element for ensuring successful implementation and management of CBHC activities. It notes that information collected and research needs must be determined by the objectives and priority needs. There is need to ensure that relevant information is collected, information needs are specified and prioritised, and that those who implement activities are also involved in gathering and utilising information.

The Conference **notes** that priority needs must be identified and participatory assessment formats developed with regular feedback provided; it **realises** that communities are capable providers and users of community based information. Therefore, their involvement in research and collection of information must be sought.

The Conference therefore ***urges*** all partners that in developing health and management information systems:

- Indigenous community information and communication systems and methods (songs, symbols, signs) be identified, recognised and integrated into the formal district and national systems and in CBHC training programmes.
- Information systems must be simple, understandable and practical, based on carefully chosen indicators that are relevant to community priorities and concerns, rather than to donor concerns only.
- Communities, with representation from all sections, must always be involved in surveys and research. The use of Participatory Rapid Appraisal (PRA) and Participatory Action Research (PAR) methods should be the main techniques for essential research. This implies participatory data analysis, interpretation and use, for simple or complex re search.



- Community structures for supporting Health Information Systems (HIS) and the function of CORPs must be identified and institutionalised.
- Community based indicators need to be identified and included in the formal information system at all levels.

The Conference ***notes*** that while the current methods of health information systems adopted and used at the community level are appropriate with regard to level of skill, cost effectiveness and dissemination potential, the flow of information is predominantly directed to serve the national system or government purposes. Similarly, research carried out in the community is rarely shared with, nor benefit them.

The Conference therefore appeals to all concerned partners:

- To recognise, institutionalise and promote community based participatory approaches to assessment, monitoring, evaluation and research.
- To include these methods and approaches in CBHC training programmes.
- To reflect the approaches in policy development, financing and resource allocation.
- To develop comprehensive guidelines for participatory methods in community based information systems.
- To develop continuous community interests and involvement in community based information systems. These may include feedback to communities and leadership development.
- Ensure community leadership, and ownership in research and evaluation outcomes.

The Conference ***recognises*** the need to use information technology for the benefit of the community. Information-gathering needs to be designed to relate to the community and to be fed into the global system in order to supply users at all levels with the necessary information regarding impact and progress of community based initiatives. Therefore, information-gathering processes:

- Should include a clear understanding of who intends to use information, how and when.
- Should be manageable in terms of size, i.e. the simplest, minimum package, required for making decisions.
- The methods used in sharing information should be friendly to the local situation and aim at involving communities in simple information analysis, to enable them to prioritise issues. Only essential information should be collected which tells them most about expressed needs reflected in the objectives and activities of CBHC programme.
- Appropriate information system is highly dependent on functional information storage and dissemination. Strategies for linking and channelling community based information from various stakeholders (Ministry of Health, NGOs, community) to the global system is important and will increase the values and potentials of available information networks.
- Information system should be designed and implemented within the available resources of the programme, ensuring regular feedback as an effective motivation and promo-

tional tool to enable the community, government and donors to see their roles in information systems and research, particularly in analysing, interpreting and using information.

7.2 Other Research Initiatives

The Conference is ***concerned*** that research in CBHC continues to be externally driven, with research agendas having little relevance to community problems. Research results are not shared with communities, or even between researchers, due to inadequate collaboration with and between research institutions. The planning and design of research methods are often carried out with no involvement of communities and with little emphasis on qualitative research.
The Conference participants led by the working group on Community Action for Health ***appeal*** to all involved partners:

- To demystify research and involve communities in determining the research agenda, as well as encouraging communities to be more observant, inquisitive and analytical in their day-to-day life, prioritising their health needs according to occurrences and trends of diseases and vital events. Management challenges (local epidemiological data, logistical and managerial problems) in and around their communities and within their projects. Communities should be assisted to appreciate the value and use of research in trying to solve their problems.
- To help people to explore their situation objectively, to find out deficiencies and to formulate an appropriate response through decisions, attitude and behaviour change and actions.
- To strengthen local infrastructure, promote local skills, and enable critical analysis of situations, projects and programmes for effective planning and action, while ensuring an enabling environment.
- To involve the communities in the planning, execution and analysis of research.
- To train health and development workers and researchers to use participatory approaches in selecting research questions, designing methods of investigations and data collection, processing and analysis. All results should be disseminated, by giving direct feedback to the community and other stake holders.

8. ALTERNATIVE HEALING SOURCES, RESOURCES AND METHODS

8.1 The role of Congregational groups

The Conference ***recalls*** the definition of congregational groups as a regular assembly of people with common interests or purpose that can provide a basis to the community based approach to health and healing through sub-groups with common identities, pooling varied talents, resources and expertise.

The Conference is ***aware*** that the mandate of the Church is to restore humanity to a state of harmony with self, neighbour and God. This state of comprehensive well-being is exemplified in the life of the early church as a healing community. It provides useful characteristics for the development and recognition of healing communities in our congregations.

The Conference ***notes*** that our Congregational communities are deeply rooted into communities and could provide a vital resource for health and healing which remains largely untapped. Mutual loyalty and support in such groups provide a context for meeting physical, social, economic and spiritual needs, and is vital to health, healing and wholeness.

Church organisations have abdicated their responsibility in health and healing to the medical professionals reducing their role in health to medical work, praying for and visiting the sick. The Churches are not consciously and deliberating exercising their unique holistic healing roles as instructed by Christ. The church leadership is not demonstrating the awareness that matters of health and healing must go beyond the perimeters of the health and medical facilities into communities. Congregations form the most effective focal points to anchor healing activities. The practical application of the teachings of scripture and similar religious books has clear guidelines on how to bring about health, healing and wholeness through a participatory process of engagement. The kind of healing sought includes the healing of conflicts, bitterness, resentment, hostility, prejudice and all the elements that influence mental, spiritual and physical health.

The Conference ***realises*** that the main business of the congregation is community-building and that religious congregations have tremendous capacity to build healing communities. They in the end become the concrete agents for health, healing and wholeness.

The Conference ***recognises*** that other existing association groups such as sports, gender, cultural groups and clubs (which are not induced by prospects of external funding) make up the sinew of the community and can engage in sustainable action for health. With proper orientation, public and private structures, institutions, businesses and professional resource persons can make meaningful contribution to action for health and development.

The Conference ***recommends*** that the Congregational networks:

- Carry out a rapid assessment to determine the role and function of the church in health and healing, to strengthen it through action-oriented awareness; undertake training for transformation workshops aimed at enhancing the understanding of religious leaders and workers on the unique role of congregational groups as agents of health, healing and wholeness.
- Urge churches and religious groups to create an environment in which healing is an integral part of the life of the congregation.
- Develop tools, methods and techniques for building healing communities and activities through these mutual caring healing groups, as well as guidelines and manuals on starting and managing healing groups.
- Develop healing partnerships or coalitions (hospitals, congregations, training institutions and communities) to enhance the capacities of all to be healers of one another; produce care-givers who are trained effectively for their facilitatory role.
- Recognise the practices and rituals in the community and congregations which build

mutual loyalty, mechanisms for obligatory sharing and caring, compassion, co-operation, collaboration and co-operation within a comprehensive socio-cultural context. These factors are vital to health, which is understood as a state of well-being. Recognition of these practices would add to the enabling environment for effective community based actions for health and healing.

The Conference ***appeals*** to intergovernmental, government, and non-governmental health agencies and networks:

- To recognise and strengthen congregational networks at local, national and international levels and to enhance their effectiveness and sustainability.
- To recognise congregations as a primary vehicle for comprehensive health and healing.
- To recognise alternative healing systems and resources as authentic elements in the District Health System, with established mechanisms for collaboration.
- To recognise and respect traditional values and healing practices.
- To transform the training curricula of health personnel to enable them to work in partnership with all health and healing resources at community level.

8.2 Harmful healing practices:

The Conference ***recognises*** that both western and non-western medical practices have harmful, neutral, and useful elements of healing. Some western healing behaviours may conflict with cultural norms and expectations. Health professionals tend to despise or ignore useful non-western healing practices based on the cultural context in which they are practised. Non-western models have greater caring than curing components.
This Conference ***calls for***:

- The recognition of alternative skills, sources and resources for health and healing.
- Organised dialogue among all partners (Congregational groups, medical professionals, and traditional practitioners) in health and healing for mutual learning, enhancement and education. The results of such dialogue should be widely disseminated to help in the process of generating standardised healing practices beyond the health facilities. There is need to develop institutionalised mechanisms for collaboration and joint action in the healing ministry. Each group of practitioners participates from their areas of strength for the good of those in need of healing, targeting the poorest sectors of the community with the most appropriate technology for care. The care should be accessible to all and fit into the socio-cultural and economic situation of the people.

The Conference ***notes*** that traditional ways of life, including health care systems have been severely eroded through colonisation, education, industrialisation, urbanisation, religion and the current globalisation of communication. Many communities are simultaneously faced with different systems, values and messages from which they have to choose while the professional service providers are unable to recognise these conflicting or competing systems and cannot bridge the gap between them. This leads to community action being encouraged only from one perspective, in total disregard of the culturally based systems, values and resources.

This Conference ***affirms*** the value of both western and non-western systems of care. It is the responsibility of health and development workers, and concerned leaders to engage all the resources and structures within the community for health care.

9. POVERTY AND HEALTH

9.1 Access to health care for the poorest of the poor

The Conference ***recognises*** that the improvement in mortality trends in the 1950s, 60s and 70s has been slowed or even reversed in the 80's and 90's due to the global recession and the debt driven export-oriented structural adjustment programmes. The impact is greatest among the poorest and the most vulnerable, as the wealthy 20 percent of the world's population continues to consume 80 percent of the world's resources. The gap between the rich and the poor continues to widen without safeguards for the most vulnerable, resulting in inability to pay for services. Those in greatest need of opportunities, care and services are excluded.

The Conference is ***aware*** of the efforts by intergovernmental agencies to focus on assisting the poorest groups by the provision of certain essential clinical packages, mainly at the primary and secondary levels. This approach ignores the multi-causal nature of ill-health, particularly in poor communities and that such prescriptions could improve the present situation in health if democratic systems and controls were in place. This would allow for the involvement of the poor users in decision-making which is not controlled by the economically and politically powerful without practical accountability to the majority of the community.

The Conference is ***concerned*** about cost-sharing schemes in health care that do not adequately address the issues of equity, sharing, and mutual caring for all people, and do not ensure care in facilities that are often unfriendly, inaccessible, un-affordable and uncaring to those in greatest need. The Conference is ***concerned about*** propositions to improve services by allowing free markets to take over without democratic controls, emphasising economic growth despite its human and environmental costs.

The Conference is ***aware*** that even the community approach that encourages active involvement may discriminate against the poor, as they may not be able to afford the time necessary for what health providers call participation. Priority target groups may be the least likely to be involved in decisions and actions controlled by professionals and outsiders. Their participation is further limited by the fact that their agenda is already taken up by the struggle to survive from one day to the next. This economic factor allows the elite to have an upper hand in collective decision-making in matters of health and development.

The Conference ***appeals to*** CBOs, NGOs, governments, intergovernmental organisations and donor agencies:

- To preferentially support integrated and comprehensive programmes that include sound poverty reduction schemes as essential elements in community action for health.
- To develop guidelines on representation and participation of the poorest of the poor in community based decision making structures.

- To mount an awareness programme for leaders and communities and to encourage them to identify with the poor through existing societal mechanisms.
- To use a participatory approach to all planning activities and identification of resources and gaps with the aim of increasing capacity-building for the community as a whole, and for the poor in particular.

Recognising the adverse effects of macro-economic policies on the poor, resulting from prescriptions of the World Bank and the IMF, the Conference ***appeals***:

- To governments, to consider and be sensitive to the effects of macro-economic policies on the poor.
- To agencies promoting CBHC to collaborate with other relevant agencies in enterprise promotion and financing schemes to assist the poor improve their economic status.
- To development agencies in collaboration with communities to advocate with governments to waive taxes on essential goods and services for poor communities.

Realising that systems and types of governance in communities tend to serve their own interests, thereby leading to mismanagement of resources at the community level, the Conference ***appeals*** to CBOs, NGOs and government structures to:

- Ensure inclusiveness and representativeness in community based governing structures with a deliberate aim of reaching out to the poorest of the poor, and to establish a functional partnership for decision-making.
- Conduct training on resource development and management to respond to community needs but building on their capacities.
- Safeguard the interests of the vulnerable majority from the greed of the privileged minority, and to enable the vulnerable to take positive action for health in ways that they can afford.
- Facilitate, promote and contribute to changes in the social, political and economic structures that perpetuate injustice. Only this kind of change can lead to better distribution of resources and services, thus making health a possibility for all.
- Challenge the unjust structures and make demands on local and national authorities to address the needs of the people.

The Conference is ***aware*** that the existing inequities in health status at community, country and international levels are economically determined, are unacceptable and are common concerns to all people of the world.

The Conference is ***convinced*** that achieving Health for All is dependent on reducing inequities in health status and access to health care. It ***notes*** that the period since Alma Ata has been characterised by a dramatic widening of the equity gap. There has been a doubling of the number of people living in extreme poverty to 1.5 billion, with 16% of the extreme poor living in sub-Saharan Africa which is half the population of the region.

The Conference ***resolves*** that:

- The future impact of CBHC activities must be measured in terms of improved health status of the poorest households in the population. This will apply to all activities including those whose primary aim may be to improve the economic well-being of communities, and those concerned with health care delivery.
- The initiation of a community based programme must always be a participatory and systematic assessment of community needs, capacities, assets, investments and priorities, using PRA or PAR. This ensures that the poorest and most vulnerable members of the community participate as equals and that all factors affecting the wealth and health of the community are analysed. In this way communities can make informed choices on a wide range of issues affecting their health and well-being.
- Regular monitoring and evaluation of community action for health should be undertaken and strengthened using participatory methods. Not only will this reinforce community empowerment, but it will also ensure objectivity and transparency in tackling the needs of the poorest households.
- Participatory analysis and assessment should also be the key to identifying the most effective experiences and practices to be promoted in spreading and replicating CBHC within and between countries. To strengthen this documentation, CBHC programmes should form partnerships with individuals and institutions such as universities, to strengthen analytical expertise.
- CBHC activities should continue to emphasise coordinated, integrated and holistic approaches to improve the health and wealth of the poor. This means that health workers should advocate and promote partnerships between communities and colleagues with expertise in fields such as education, environmental protection, housing, food security, creation of income generation enterprises, savings and credit.
- Include dialogue, negotiation and advocacy with governments and donors among the essential CBHC activities with the objectives of increasing awareness on the realities at community level. The aim is to build consensus on policies to support, and not to frustrate community self-reliance, particularly by the poorest groups.
- Sound social and economic development at all levels, in the context of the global trends is vital to the attainment of better health in the poorest regions and pockets within countries and communities. Poverty alleviation and dependency reduction are essential to reducing the gap in health status between the rich and the poor. The promotion and protection of the health of people are essential to sustained economic and social development, and contribute to improved quality of life and world peace.

10. ACTIONS FOR HEALTH IN DISASTER, EMERGENCIES AND CONFLICTS

The Conference is ***aware*** that often, there is lack of or appropriate interventions in the context of disaster, emergencies or armed conflict. It ***notes*** that often, changes happen during crises and problems when people are forced to consider the need for change more seriously.
This Conference **appeals** to all CBOs, NGOs, governments, intergovernmental agencies and donors to work in partnership with local Communities:

- To carry out a rapid assessment to determine the need and level of initial inputs into relief, and before any intervention is undertaken, to carry out a detailed assessment to guide longer term response.
- To carry out continuous monitoring and timed evaluations as part of the key interventions. Tools for monitoring and evaluation activities should be developed.
- To develop standard protocols relevant for different types of disasters. These protocols may include the following:

    - Code of conduct to govern the behaviour of relief agencies in the field;
    - Minimum qualifications of personnel;
    - Standardised approaches and procedures in relief health and operations;
    - Co-operation with other actors in relief.

- Be aware of the need and the possibility for change, and provide necessary leadership for change.

The Conference ***notes*** the lack of collaboration between communities, governments and NGOs in disaster preparedness and management. Often outside agencies enter communities without adequate consultation with the local population to their detriment.

In relief operations, the local community bears the brunt of relief operations, for example, environmental degradation, increasing prices of essential goods, emergence of new diseases, destruction of local infrastructure, and in instances of refugee situations, even the host government is sidelined.

The Conference is ***aware*** that there is inadequate collaboration between key actors, with each carrying out competitive, and at times antagonistic activities that do not complement each other.

The Conference ***urges*** all partners involved that in all disaster interventions:

- A memorandum of understanding should be developed between the host government and community and all implementing agencies, to clarify roles and responsibilities, and to specify levels of commitment in terms of time and resources.
- Mechanisms for interfacing between communities, NGOs, governments and international agencies should be developed (including communication strategies between communities and external agencies and governments; there is need to build the capacity of the community in monitoring food security, and in managing and maintaining equipment and assets).

The Conference is ***concerned*** about the non-recognition of the capacities, efforts and contributions of the local communities in response to disasters and emergencies by the external agencies and the media. Yet local communities are usually the first respondents to any disaster situation. During a refugee influx, their compassion and the components of food, energy, health services and other resources are the first to be depleted. Usually they are confronted with these issues, yet have no skills or indigenous organisations for disaster response.

The Conference is ***concerned*** that relief interventions tend to relegate people to recipients and clients, and thus undermines their coping capacity and mechanisms. They rarely use traditional resources due to emphasis on external, technical and material inputs, which often arrive too late and stop too early.

This Conference ***requests*** governments and collaborating NGOs:

- Initiate, strengthen, keep in a state of preparedness and use existing systems and structures at all levels and in all sectors.
- Involve local communities in all stages of planning and decision making, implementation and evaluation of relief and rehabilitation activities.
- Strengthen community capacities in all entry borders.
- Compile an inventory of existing resources and predict the potential deficit through utilisation by utilisation by disaster victims.

The Conference ***recognises*** the need for adequate and appropriate political commitment at local, national and international levels. International, national and locally developed indicators to monitor disasters do not exist. Responses are left to any individual to be determined predominantly by political and not humanitarian imperatives.

This Conference ***urges:***

- Governments, NGOs and international agencies to ensure the promotion of community advocacy on disaster, supported by appropriate and sensitive early warning systems for all forms of potential disaster.
- The Communities, NGOs and international agencies to ensure documentation, continuous flow, dissemination and sharing of information with authorities, including politicians.
- Governments not to use disaster as a political tool, nor have political considerations, but to have humanitarian considerations for action.

The Conference ***notes*** that in many instances, communities, NGOs and governments have exhibited lack of capacity to respond, particularly in situations of complex disasters. There are no appropriate training programmes on disaster management, preparedness and prevention in training institutions;

Aware that the Health for All Declaration of 1978, did not include the prevention and management of disasters, and yet disasters are now among the commonest causes of human deprivation and death throughout the world, this Conference ***appeals*** to:

- Governments, NGOs and international communities to develop and activate appropriate national and local disaster preparedness bodies.
- Training institutions, with the support of governments, international agencies and NGOs, to introduce disaster management, as a substantive course particularly in all relevant fields of study (health, environment, agriculture, development, etc.)
- WHO to include a statement in the renewal of Health for All recognising and endorsing all forms of disaster as a major issue, and to develop strategies and guidelines on its management.

- Countries should set up disaster funds and mobilise finances towards its realisation.
- Countries should provide and train people to use modern communication equipment.
- Countries should collect, adapt and distribute emergency guidelines, including those related to personnel and security.

Dr. Michael Gerber - DM Amref, Dr. James Mwanzia - DMS Ministry of Health Kenya, Hon J. K. General Mulinge - Ministry of Health Kenya, Dr. Kasere - DM CISS International

In conclusion the First International Conference on CBHC **calls** for urgent and effective individual, community, agency, national, and international action to develop and implement CBHC throughout the world, particularly in developing countries. It urges governments, WHO, and UNICEF, and other international organisations, multilateral and bilateral agencies, NGOs, funding agencies, all health and development workers and the world community, to support an international, national and community commitment to CBHC development. It calls for channelling increased technical and financial resources, particularly to developing countries. The Conference calls on all the participants and all the aforementioned, to collaborate in introducing, developing, managing, and maintaining CBHC in the spirit and content of this Accord.

The Conference participants **resolve** to struggle on the side of the most vulnerable and the poor in rural and urban communities. The participants **advocate** for good governance, ensuring accountability to communities in which we live and serve. They call for democratic principles, increased transparency and basic human rights, and increased role and status of women. The participants **plead** for community involvement in the formulation of policies and in decisions that affect the allocation of resources, in keeping with the priorities of the most vulnerable: the poorest of the poor. Participants at this Conference will serve as prime movers for change in partnerships, with all partners relieving the plight of the poor and suffering, and making health and well-being a possibility for them. New partnerships should be provided to create and maintain an enabling environment for community self-reliance, empowerment and transformation. There is need to lobby policy makers and to be politically active in all ways possible and necessary to ensure achievement of the Health for All goal.

Finally, this Conference has provided an opportunity for a re-examination of the causes that perpetuate underdevelopment, especially among the poorest groups. We need to undertake a critical analysis of the causes, consequences and cures for poverty, disempowerment and under-development: institutions, concepts, policies and practices that shape the inequitable global economic system and that impinge on the well-being of people. We must follow the chain of causes all the way to the source. In the final links, we may begin to rediscover ourselves through the eyes of our own dispossessed and hungry - our value judgements, our life-styles, our governments. This discovery should move us to action in solidarity with the poor and most vulnerable.

This Conference **challenges** us all to subject our past and present realities to a radical appraisal. By doing this, we should find the motivation to renew our commitment to the Health for All strategy, through a process that lead to the **transformation** of systems and societies in which we are involved. This transformation process should involve the true **liberation** of every person from personal, social, cultural, political and economic limitations, and should empower each person for the achievement of their full potential. They will thus be able to cope with daily challenges, problems, needs and responsibilities of life, and thereby achieve the Health for All goal.

All participants at the Conference, countries, NGOs, CBOs, individuals and players **resolve** to cooperate in partnership, to ensure effective community action for health at all levels and thus develop CBHC all over the world. All participants at the Conference will submit reports to the Secretariat, at least once a year, regarding their own progress and the progress of their communities, districts, countries or agencies in implementing specific elements of this Accord of particular relevance to them. These reports will be published in a continental newsletter. Best performances will be recognised at the next International CBHC Conference in the year 2000.

MONITORING AND EVALUATING THE IMPLEMENTATION OF THE NAIROBI ACCORD

All the participants at the Conference will endeavour to not only be the advocates of the Accord, but also documentors of actions, outcomes and changes arising from it. Participants and other interested agencies are encouraged to send regular information, regularly, to the post-Conference Secretariat, where the information will be processed, analysed and disseminated through regular publications and newsletters. The Conference suggests the indicators below:

INDICATORS:

Enabling environment for Community Resource People:

1. The number and proportion of CORPs attending national and international meetings and courses (by gender and age).
2. Criteria for selecting community participants for meetings and for assessing their level of participation at such meetings developed, disseminated and utilised.
3. The number of donors requiring percent participation of Community people in decision making fora, as a pre-condition for financing.
4. Proportion of national health budgets earmarked for community based initiatives
5. Guidelines for the establishment and management of BI programmes developed and disseminated.
6. Number of countries with organised support for BI, including training programmes, relevant supplies, systems for procurement and distribution of supplies, supportive supervision, monitoring and evaluation, and an information system.
7. The development of strategies and implementation guidelines for partnerships with communities.
8. The number of countries in which CBHC is integrated into district health systems.
9. The number of CORPS trained to a level of recognised certificates.
10. A list of non-monetary incentives developed for CBHC workers.
11. The number of CBHC projects proposed, promoted and developed by community members.
12. The number of CBHC projects in which community members participate at all levels of governance, management and operations.
13. The number of institutions playing more meaningful roles in facilitating development of CBHC activities and contributing relevant knowledge and skills to solve community or project specific problems.
14. The number of community structures with capacities to sustain, initiate own projects or engage in meaningful partnerships with external agencies.
15. The number of institutions in partnership with communities for review of own curricula, and in community based and problem-focused approaches.

Facilitating and supporting Community Action for Health

1. The number of governments with a policy framework for the support of CBHC activities resulting from a participatory process in policy dialogue.
2. Characteristics of community partnerships programmes established and disseminated
3. The number of well functioning community partnerships programmes and populations covered by well functioning community partnerships programmes.

Training and leadership development for health and development

4. Essential characteristics of CBHC leadership established and disseminated.
5. The number of CBHC leaders trained and involved in a programme (community, district, national and international levels).
6. The number of CBHC workers going through training and leadership development.
7. The number of people trained in CBHC by category; improvement in KAPS in CBHC among health workers and improvement in the health status of the target communities.
8. The number or proportion of CBHC projects that are initiated or run by communities themselves.
9. Change in KAPS with regard to the Management of Community Based Programs (CBPs).
10. Characteristics of a well functioning Community Based Program developed and disseminated.
11. The number of CBPs with the essential characteristics including the populationscovered by such programmes.
12. The number of health problems managed well at the household level, and KAPS on such programmes (at the level of service providers, CORPs, and the general community).
13. The number of national health systems in which policies clearly assign roles at household, community, health unit, district and national levels to address the most common health problems, including a system put in place to monitor performance and to evaluate results.
14. Essential characteristics of a well functioning community structure for partnership in health and development.
15. The characteristics of a well functioning school health programme developed and disseminated.
16. Guidelines for community based school health programmes developed and disseminated.
17. Number of schools running an effective school health programme based on pre-agreed indicators (KAPS for teachers, parents, pupils and changes in the school environment and community).
18. Production and dissemination of guidelines for effective community based information systems, rapid appraisal, action research, monitoring and evaluation.
19. The number of programmes with functioning community based information systems (including community based resource centres).
20. The number of research teams, papers, publications incorporating community members.
21. The number of community based conferences, and publications by CORPs
22. The number of innovative participatory research projects, using multiple methods of data collection validation and analysis, particularly approaches in data collection analysis and validation.
23. The number of communities using statistics and epidemiological data to state their problems.

being more inquisitive about the output and results of interventions using simple indicators such as reduction in deaths, or increase in occurrence of diseases, or improvement in access to basic needs.

Alternative sources of health and healing

1. The number of churches and other religious groups with recognised healing activities that are based on the life of its congregations as a worshipping community.
2. The number of healing groups started.
3. Change in knowledge, attitude and practice (KAP) regarding health and healing beyond the immediate congregational group.
4. The number of groups and congregations who have carried out a rapid assessment of needs and capacities, as a basis for planning action and targeting the poorest members in their constituency.
5. Characteristics of a well-functioning resource generation, poverty alleviation and dependency reduction initiative project.
6. The number of programmes by population, covered with the essential characteristics.
7. Guidelines for effective resource generation, poverty alleviation and dependency reduction in CBHC (including credit facilities) developed and disseminated.
8. Change in KAPS regarding appropriate and effective use of savings and credit facilities.
9. Guidelines for effective health financing schemes developed and disseminated.
10. The number of well functioning health financing schemes.

Community action in Disasters, Emergencies and Armed Conflict

1. Guidelines for disaster prevention, preparedness and management developed and disseminated.
2. The number of countries, NGOs and communities with functioning disaster prevention, preparedness and management programmes.
3. The number of training programmes on disaster prevention, preparedness and management.

List of Papers Presented at the 1st International CBHC Conference 17-21 March, 1997, Safari Park Hotel, Nairobi Kenya

Opening Speech by Hon. Gen. (Rtd) J K Mulinge, EGH, MP, Minister for Health of the Republic of Kenya.

A. Main Theme : Community Based health Care Beyond the Year 2000

1. "Better Health in Africa: Towards Health Sector Reform"
Prof. Olikoye Ransome-Kuti, Chair, Better Health in Africa Expert Panel, World Bank.

2. "Developing Leaders or health Systems for Health for All: Which Comes First?
Dr Miriam K Were, Director, UNFPA Country Support Team for East and Central Africa, Addis Ababa, Ethiopia.

B. Enabling Environment:

1. "Policy Guidelines which provide Enabling Environment for Health for All"
Dr Kopano Mukelabai, UNICEF Representative in Eritrea.

2. "Sustainable Development and guided community participation"
Michael S Gerber, Director General, African Medical Research Foundation (AMREF)

3. "A global perspective of rational management of essential drugs as a tool for quality care for all"
P Graaff, WHO Programme Coordinator, Kenya National Drug Policy Implementation programme, Ministry of Health, Nairobi, Kenya.

4. "Better Health for All. The Ugandan Experience"
Dr J Tumwine, Makerere University.

5. "Better Health for All. The Kenyan Experience"
Dr B Hagembe, Ministry of Health, Republic of Kenya.

6. "Better Health for All. The Namibian Experience"
G Muballe, Ministry of health, Republic of Namibia.

7. "The effect of Health Service Reforms on the Hospital/Community Facility Manpower Mix"
Ms S Riba, Head of Nursing Department, Ministry of Health, State of Israel.

8. "The District Health System in Support of CBHC Initiatives on Going to Scale towards Health for All"
Dr J Maneno, Consultant CISS International, Nairobi Kenya.

9. "Comprehensive resource based approach to effective District Health Service Management"
Dr G Rae, Consultant, CISS International, Nairobi, Kenya
Dr G Rae, Consultant, CISS International, Nairobi, Kenya

10. "Planning and supervision of Mother and Child health Care towards achieving Health for All"
Dr J Alwar, Consultant, CISS International, Nairobi, Kenya.

11. "Pertinent strategy within the health system to ensure health for all"
Dr P Mwanzia, Director of Medical Services, Ministry of Health, Republic of Kenya.

12. "Community Health Centres in rural Eastern Cape"